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**OFFICE OF
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The External Review of Hospital Quality

State Initiatives



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EXECUTIVE SUMMARY

Purpose

To describe State government initiatives concerning the external review of hospital quality.

Background

State Initiatives Aimed at Hospital Oversight

State agencies play important roles in overseeing hospitals, either as agents of the Health Care Financing Administration (HCFA), or under their own authorities to license such facilities and protect the public. Indeed, many States have developed and implemented initiatives aimed at addressing the quality of care in hospitals. This report presents a snapshot of six such initiatives that appear promising and could be instructive not only to other States but also to the Federal government. We present the initiatives in three categories: standardized performance measures, on-site surveys, and public disclosure of information on hospital performance.

This report is a follow-up to our recent series of reports that assessed the roles of HCFA and the Joint Commission in overseeing hospitals that participate in Medicare. In that series, we directed recommendations for improvement to HCFA.

Our information comes from discussions with the pertinent State officials and reviews of relevant documents.

Standardized Performance Measures

These are quantitative indicators that enable regulators, purchasers, and consumers to compare hospital performance to itself over time or to other hospitals. They can provide insights into a hospital's performance, foster improvements, and identify outliers.

New York: Using Mortality Data to Measure Hospital Performance

New York collects and publishes mortality data on coronary artery bypass graft surgery (CABG) and other procedures, fulfilling both quality improvement and regulatory functions.

Pennsylvania: Creating Performance Report Cards

Pennsylvania analyzes inpatient data from every hospital in the State to create reports that evaluate hospitals on quality-of-care measures such as length of stay, charges, and admission rates for CABG, breast cancer, and diabetes, among others. In 1998, it documented a 22 percent drop in in-hospital mortality for CABG from 1991 to 1995.

On-site Surveys

On-site surveys are a traditional way to assess directly a hospital's compliance with Federal, State, and local requirements. Many States, however, largely rely on the Joint Commission on Accreditation of Healthcare Organizations or surveys funded by HCFA for an on-site presence in their hospitals.

Utah: Observing Accreditation Surveys

Utah relies on surveys by the Joint Commission to determine compliance with its hospital licensure requirements. However, Health Department officials participate in the summary session at the end of the Joint Commission's on-site survey. The Department looks to the findings of the Joint Commission in determining whether to pursue its own enforcement actions.

New York: Surprise Inspections of Residency Programs

In 1998, New York launched 12 simultaneous surprise inspections of residency programs at teaching hospitals across the State. New York regulates resident working conditions, and these surprise inspections marked the State's first effort to ensure compliance.

Public Disclosure through the Internet

The Internet provides enormous opportunity for sharing performance information quickly and broadly. It can spur hospital improvements and reassure the public that an external review process is protecting its safety.

New Jersey: Listing Hospital Enforcement Actions

New Jersey's website details resolved hospital enforcement actions, such as fines or other penalties imposed for violating licensure or certification regulations. The website also includes information about the State's inspection, licensure, and complaint processes. It updates the site quarterly.

Colorado: Posting Compliance Summaries

Colorado posts hospitals' compliance histories on its website. In addition to basic hospital information, the website includes a summary of all complaints and serious events reported to the State since January 1999. The summaries describe the reported incident, what actions the facility took in response, and the Department's follow-up actions.

Conclusion

The State initiatives presented in this report show that States can draw on their own authorities and resources to add a measure of public protection not provided by either HCFA or the Joint Commission. The States have advantages, such as simply being closer to the action, that national reviewers would be hardpressed to match. And these advantages help States contribute a valuable complement to the existing, national approaches to external hospital review.

State initiatives can also serve as important catalysts for continued national efforts aimed at improved hospital oversight. Indeed, the States' experiences can be instructive to HCFA, the Joint Commission, and other States. The initiatives highlighted herein reinforce themes of balance and accountability that we promoted in our prior inquiry, which assessed the roles of HCFA and the Joint Commission. The States' experiences with performance measures, surprise inspections, and public disclosure demonstrate that such efforts can be both feasible and constructive.

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INTRODUCTION

PURPOSE

To describe State government initiatives concerning the external review of hospital quality.

BACKGROUND

States as HCFA Agents

State agencies play important roles in helping the Health Care Financing Administration (HCFA) ensure that hospitals meet the minimum requirements for participating in the Medicare program. Funded by HCFA, they conduct validation surveys of those hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations, determine Medicare certification for those hospitals that choose not to be accredited, and respond to complaints and adverse events involving hospital care. In a number of recent reports, we addressed how the States performed these roles and how HCFA held them (and the Joint Commission) accountable for their performance.¹ We directed our recommendations for improvement to HCFA, which responded with an action plan.

States Under their Own Authorities

During the course of our prior work, we learned of initiatives that State governments were taking under their own authorities to address the quality of care provided in hospitals. Many of these were significant initiatives that could be instructive to the hospital quality review efforts of the Federal government and of other States. In this report we offer a snapshot of six such initiatives.

We found each of the initiatives promising enough to warrant wider attention, although we did not evaluate them. Our information comes from discussions with pertinent State officials and from reviews of relevant documents (see appendix A for more details on our methodology). We do not suggest that the initiatives presented here represent a comprehensive listing of quality review efforts being undertaken by the States; nor do we suggest that they have necessarily been successful in achieving their objectives.

We present the initiatives in three categories: (1) standardized performance measures, (2) on-site surveys, and (3) public disclosure on hospital performance. We begin each by discussing the relevance of these categories to the external quality review of hospitals.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Standardized Performance Measures

Tools for Improving Performance and Enforcing Minimums

Standardized performance measures are quantitative indicators that enable regulators, purchasers, and consumers to compare hospital performance and ensure that patients are receiving quality services. The comparisons can focus on a hospital's own performance over time and/or how its performance compares to other hospitals. Examples of performance measures include rates of complication from specific procedures and the preventive administration of antibiotics prior to surgery. The data can be drawn from sources such as a hospital's records, billing claims, or surveys of patients or providers.

External reviewers can use performance data in two fundamentally different ways, both of which have value. One way is at root collegial: to foster continuous quality improvement. External reviewers collect performance data and distribute them with the intent of providing hospitals with comparative information they can use, voluntarily, to improve their own performance. If particular hospitals find that their performance is significantly poorer than that of others, they can search for factors that explain the difference and for changes that will improve their performance.

The other way is more regulatory: to identify hospitals that are performing poorly in relation to any of the designated measures and to hold those hospitals accountable for raising their performance to acceptable levels. External reviewers encourage the hospitals to improve voluntarily, but could also mandate corrective actions and even penalties.

Realizing the Potential

The Joint Commission on Accreditation of Healthcare Organizations has been one of the leaders in recognizing the potential of standardized performance measures. More than a decade ago it set forth a vision for hospital accreditation that would be based largely on data-driven clinical performance indicators. But its progress toward this end has been much slower than envisioned because of a number of significant obstacles. Three such obstacles have been particularly prominent: (1) the technical difficulties associated with the science of measurement and risk management, (2) the costs involved in collecting and distributing data, and (3) the political concerns raised by sharing performance data with others.

Although these obstacles remain imposing, the quest to institutionalize performance measurement remains strong. The Joint Commission requires, at a minimum, that accredited hospitals use a performance measurement system from its list of approved systems. Furthermore, in an effort to foster consistent national standards for performance measurement, the Joint Commission recently joined with the American Medical Association and the National

Committee for Quality Assurance to create the Performance Measurement Council. And at the Federal level, HCFA, in the proposed revisions to the Medicare conditions of participation, stresses the potential of performance measurement and calls for Medicare-certified hospitals to conduct a minimum number of performance improvement projects

In the presentations below, we address the considerable experience that Pennsylvania and New York have had in using discrete hospital performance measures.

NEW YORK: Using CABG Mortality Data to Measure Hospital Performance

New York's Department of Health publishes reports on risk-adjusted coronary artery bypass graft (CABG) mortality rates. The annual reports present the number of CABG surgeries performed, the number of deaths, and three types of mortality rates for each surgeon and hospital in the State (see box). The Department distributes about 2,000 reports per year, which also are available on the Internet.

Risk Adjusting and Public Scrutiny

Development of these measures began in 1988 at the direction of the Department's Commissioner as a way to understand the disparities among the mortality rates from CABGs in the State's hospitals. A Department statistician developed the risk-adjustment methodology based on risk factors compiled by the State's Cardiac Advisory Committee, a longstanding group of cardiologists and cardiac surgeons that advises the Department on cardiac-related matters. These risk factors include age, gender, comorbidities, and previous open heart operations.²

Mortality Rates

Reports published by the New York Department of Health present three mortality rates for each surgeon and hospital included:

Observed mortality rate - the number of observed deaths divided by the total number of patients who underwent isolated CABG surgery.

Expected mortality rate - the sum of the predicted probabilities of death for all patients divided by the total number of patients.

Risk-adjusted mortality rate - the best estimate, based on the statistical model, of what the provider's mortality rate would have been if the provider had a mix of patients identical to the statewide mix. The report also presents a confidence interval for the risk-adjusted mortality rate.

Source: Coronary Artery Bypass Surgery in New York State 1994-1996, New York State Department of Health, October 1998, p. 8.

The Department released the first risk-adjusted CABG mortality rates in 1990 for each hospital. An article on the data in the *Journal of the American Medical Association* noted that surgeons performing fewer CABGs had mortality rates that were higher than the surgeons who performed a higher volume of CABGs.³ Following this, a Freedom of Information Act request and subsequent lawsuit by a New York newspaper led to the release of surgeon-specific data. The Department now analyzes and reports data on individual surgeons who have performed 200 procedures over a 3-year period or performed at least 1 procedure in each of the 3 years evaluated.⁴

Since 1994, the Department has published a similar report presenting angioplasty mortality data. Within the next year, it will begin publishing a report with data on heart valve surgery mortality rates.

Quality Improvement and Regulatory Effects

The publication of the data has spurred both regulatory actions on the part of the State as well as improvements in the quality of care provided in the hospitals. Risk-adjusted data enable the Department to compare every facility's outcomes on a level playing field. The Department has used the risk-adjusted mortality rates to identify outlier hospitals, and required one such outlier to affiliate with an academic institution. It required two other hospitals to close or suspend their cardiac services as a result of their performance data.

Since the Department began collecting and reporting CABG data, the mortality rate from this surgery in New York fell from 3.52 per 100 patients in 1989 to 2.44 per 100 patients in 1998.⁵ Some hospitals in the State have initiated their own quality improvement programs based on the data from the CABG reports.⁶ For example, one hospital in the State had higher mortality rates and concluded that emergency cases were rushed into surgery without being stabilized. That hospital then made changes to ensure patients were stabilized prior to surgery, leading to an improvement in its mortality rate. In another hospital, the mortality data led to personnel changes. That hospital determined it was unable to handle the severe cardiac cases, so it referred such cases to other hospitals until it could expand its own ability to handle them.

PENNSYLVANIA: Creating Performance Report Cards

Pennsylvania, too, collects and disseminates data on CABG surgery and has done so annually since 1993. In 1998, the Pennsylvania Health Care Cost Containment Council (hereafter referred to as the Council) released its fifth CABG report, which includes risk-adjusted measures of mortality, length of stay, and average charges. The report lists each measure individually by hospital, physician, and most recently, by health plan in the State. In addition to its annual CABG reports, the Council produces other reports addressing a range of health issues such as caesarean-section rates, breast cancer, heart attacks, osteoporosis, drug use,

and diabetes. These issue briefs provide State-wide information on, for example, charges, average length of stay, and admission rates. The Council recently reissued for the first time since 1994 the “Hospital Effectiveness Report,” which includes data on 15 DRGs.⁷ For each DRG and each hospital, this report highlights risk-adjusted mortality, average length of stay, and average charges (see box).

SOUTHWESTERN HOSPITALS					
	CASES		Risk-adjusted MORTALITY	Risk-adjusted LENGTH OF STAY	Average CHARGE
AUMC - Allegheny Valley	276	⊙	7.7	\$15,370	
AUMC - Canonsburg	96	⊙	5.7	\$10,301	
Allegheny General	393	⊙	5.7	\$16,490	
Armstrong County Memorial	163	⊙	6.4	\$9,755	
Brownsville General	73	⊙	8.4	\$9,341	

Source: Pennsylvania Health Care Cost Containment Council, A Hospital Performance Report-Region 1, 1999 (99-07/04-11/1), p. 7.

Pennsylvania began this data initiative in 1986, when, at the urging of State business and labor leaders, its legislature created the Health Care Cost Containment Council.⁸ One of the Council’s charges is to contain health care costs by stimulating competition among hospitals. By compiling and releasing hospital data on charges and outcomes, the Council aims to provide purchasers and consumers with information—thereby promoting more informed decisions and choices among health care providers—and thus drive down health care costs. The 21-member Council includes representatives from business, organized labor, hospitals, physician groups, and insurance companies, as well as consumers. The Secretary of the Department of Health is also a Council member, however there is little interaction between the Department and the Council.⁹

Documented Improvements in Data Indicators

The 1998 CABG report identified a 22 percent drop in in-hospital mortality for CABG surgery from 1991 to 1995 while the number of cases in the State increased. Also, the average charge for CABG surgery decreased 3.9 percent.¹⁰ Similarly, caesarean-section rates have dropped across the State while the rate of vaginal births after a caesarean-section has increased.¹¹ Many attribute the measured improvements to hospitals’ own use of the data for internal improvement projects and to guide staff recruitment efforts.¹² There has been some debate on the actual impact on consumers of the Council’s data releases. Some argue that the data is

most helpful for hospitals and purchasers, rather than consumers. However, a 1996 survey found that 20 percent of the heart-surgery patients surveyed were aware of the CABG report.¹³

Data Collection Is Resource Intensive

These improvements come at a significant cost to hospitals. The Hospital Association estimates that the software mandated by the State costs Pennsylvania hospitals \$10 million and an additional \$40 million for the separate data abstraction. Hospitals can use the software system for their own efforts but must buy back any data generated by the State. Furthermore, hospitals are concerned about the validity of the data. They note that certain factors, such as “Do Not Resuscitate” orders, are not taken into account by the software. As a result, the data may show a hospital with a significantly higher mortality than is actually true. Despite the burden of data collection and submission, it appears that hospitals find the available data helpful.

On-site Surveys

The Core Element of the External Review Process

Traditionally, the on-site survey of hospitals has been the key element of the external review process. Through on-site surveys, the surveyors can assess first-hand how well hospitals are meeting established requirements and can offer information and advice for hospitals seeking to improve their performance. The surveyors can observe conditions, review records, and interview administrators, clinical staff, and patients.

As part of its accreditation process, the Joint Commission conducts on-site surveys every 3 years to review hospital compliance with over 500 standards in 45 performance areas. The surveys range from 2 to 5 days, depending on the size of a hospital. The Joint Commission supplements these surveys with a small number of random, unannounced, and briefer surveys intended to assess continued compliance with standards. Occasionally, it will also visit hospitals to investigate complaints or adverse events.

The State agencies also conduct surveys. For accredited hospitals, they perform validation surveys and respond to complaints and adverse events under agreement with HCFA. For nonaccredited hospitals, they conduct routine on-site surveys, but because of resource constraints they use on-site surveys primarily for responding to complaints or adverse events.

Using Survey Resources Strategically

On-site surveys serve as a central, resource-intensive part of the external review process. Given that, it is especially important that the resources devoted to on-site surveys be used strategically. Among the key questions that the Joint Commission, State agencies, and HCFA must consider are these: How can surveys best be targeted to problem areas? How often should surveys be conducted? What should be the balance between announced and unannounced surveys? Between routine surveys and surveys conducted in response to complaints and/or adverse events?

These questions have particular relevance for the Joint Commission because it accredits about 80 percent of the 6,200 hospitals that participate in Medicare and because 30 States deem hospitals accredited by the Joint Commission to meet their licensure requirements. But a number of States have taken initiatives that aim to add an on-site presence and a measure of patient safety beyond that afforded by the accreditation process. Below, we present Utah's participation in Joint Commission accreditation surveys and New York's unannounced visits to teaching hospitals.

UTAH: Observing Accreditation Surveys

Utah retains the unique authority to attend a deemed hospital's accreditation survey and to take action based on that survey. This authority allows the State to balance scarce resources and hospital burden while maintaining a prominent presence in hospitals.

Each year, when hospitals must apply for a license to operate in Utah, they have the option of initiating, continuing, or relinquishing deemed status. Thirty-two of the State's 51 hospitals are accredited and have chosen to be deemed. By opting for deemed status, hospitals forego the annual licensure surveys conducted by the State, and the State relies instead on the survey conducted by the accrediting organization (usually the Joint Commission). However, as outlined in regulation, request for deemed status automatically authorizes officials from the Department of Health to attend part of the hospital's accreditation survey. Deemed hospitals must notify the State of their upcoming accreditation surveys. On the last day of the survey, a Department official attends the closing conference. Generally, the Department official takes notes and acts as an observer, but he or she can and will ask questions if necessary. In addition, Joint Commission surveyors have, on occasion, made themselves available after the conference for further discussion. After the conference, the official reports back to the Department on all deficiencies. The Department can then take action based on this report and its assessment of the accrediting body's findings. If warranted, the Department can cite a deficiency under licensure authority while on-site and often will interview hospital officials to find out more information about the deficiencies.

Observing Accreditation Surveys Allows for Timely Action

Utah requires hospitals to submit, as many other States do, the final Joint Commission accreditation report to the State. However, the Joint Commission does not issue its final report until up to 120 days after the survey, and hospitals then have another 60 days to respond. If there were significant or immediate problems at the hospital, the Department would be unaware of them until well after the fact. By attending the conference, officials can hear the results first-hand and take immediate action if they feel it is warranted. In 1998, the Department cited three hospitals on-the-spot based on attendance at such conferences. The Department's presence at the conferences also allows it to learn about any supplemental deficiencies, which are generally excluded from the Joint Commission's final report.

NEW YORK: Surprise Inspections of Residency Programs

In March 1998, New York's Department of Health conducted surprise inspections of residency programs simultaneously in 12 of the State's teaching hospitals. This was the beginning of an effort to oversee hospitals' compliance with the State's residency law, known

as the Bell Regulations. New York is the only State that regulates resident working conditions in its State hospital code.

The State conducted the inspections by sending survey teams into the 12 teaching hospitals simultaneously on a Thursday afternoon. Surveyors then stayed on-site through the weekend. Survey teams consisted of Department field workers, including registered nurses who conducted medical record reviews to assess physician supervision of residents' cases.

The inspections focused on residents' working hours and supervision by attending physicians. Surveyors assessed compliance with the State's working hour limitations by examining posted schedules, then observing residents as they went on- and off-shift to assess their true working hours. The Department used the data collected on residents' working hours to calculate a sample work week, which estimated residents' work schedules. To determine adequacy of supervision, surveyors reviewed medical records for evidence that physicians supervised the residents' cases, and tested the on-call system by having residents contact their respective attending physicians. In addition, surveyors interviewed residents and physicians to learn more about supervision and working hours.

Bell Regulations

In 1989, New York established the Bell Regulations to cover supervision of residents by attending physicians and to limit the hours worked by residents in the State's teaching hospitals. The impetus for these regulations was the death of a woman in a New York City emergency room; a grand jury probe subsequently found problems with residency training.

New York City's public advocate published reports in 1994 and 1997 that revealed violations of the Bell regulations in New York City's teaching hospitals. The cited violations included both insufficient supervision and excessive hours worked by residents. In 1998, State legislators questioned the Department's Commissioner about Bell Regulation compliance, which led to the surprise inspections.

Violations of working hour limits

In May 1998, the Department released a report with its inspection findings. The State found supervision of residents by attending physicians that was both timely and in-person. The main problem uncovered was with residents' working hours: 37 percent of residents worked more hours than the regulations allow. Surgical residents violated regulations the most: 79 percent exceeded the working hour limits. Residents exceeded the working hour limits the most in New York City area hospitals; there, 40 percent of all residents and 94 percent of surgical residents exceeded the working hour limits.¹⁴

The Department intends to conduct these surprise inspections in each teaching hospital in the State targeted for review. To date, the Department has surveyed about 30 percent of the teaching hospitals. Once it conducts an initial surprise inspection in a teaching hospital, it plans to enforce the Bell Regulations with follow-up surveys and by assessing corrective action plans produced by the hospitals. Follow-up surveys have been conducted in 50 percent of the hospitals surveyed in the original study. Since these inspections began, the Department and the State's hospital associations have conducted training sessions on compliance with the Bell Regulations with teaching hospitals.

Public Disclosure through the Internet

A Mechanism for Fostering Accountability

With the rapid development of information technology, new opportunities have opened up for sharing more information, more quickly, to wider audiences. In regard to the external quality review of hospitals, this development means that the Internet now exists as a significant forum for informing consumers, health care purchasers, the media, and other interested parties about the performance of hospitals. The hospitals' traditional accountability to private accrediting entities and public bodies can now be supplemented with direct accountability to the public.

In particular, posting on Internet websites can be an important way for external reviewers to present information to the public on how hospitals fared during the review process. It can serve as a way of revealing hospital shortcomings as well as strengths, of indicating how performance has changed over time, and even of indicating how they compare with one another on certain measures. Furthermore, it can serve as a key motivator for hospitals to improve their performance and can reassure the public that an external review process is protecting its safety.

In the same context, the posting of information on the Internet can also be a tool for holding the reviewers--the Joint Commission, the State agencies, and HCFA--more fully accountable to the public. Such information can address the extent and type of review efforts conducted as well as any evaluative information on the reviewers themselves.

Finding the Way There

The public disclosure of information along the lines indicated above is in the earliest of stages. Little is now available. To a significant degree, the technical, financial, and political constraints that inhibit the use of standardized performance measures also restrict the use of the Internet as an information-sharing forum.

HCFA now lacks a website offering information on the performance of hospitals or reviewers.¹⁵ The Joint Commission has been more proactive in this regard as it makes hospital performance reports available on its website. But the extent and type of information it offers is minimal. A few States, acting on their own authority, are becoming even more proactive in this regard. Below we discuss the early experiences of New Jersey and Colorado.

NEW JERSEY: Listing Hospital Enforcement Actions on the Internet

In May 1998, the New Jersey Department of Health and Senior Services unveiled a website detailing hospital enforcement actions, such as fines or other penalties imposed for violating licensure or certification regulations.¹⁶ Visitors to the website can access information on resolved hospital enforcement actions in New Jersey hospitals that the Department investigated.¹⁷

The website contains documentation of the enforcement actions, as well as the actual penalty letter the Department sent to the hospital, which outlines the findings of the investigation, describes the licensing violations in greater detail, and gives legal citations for each violation (see box). It also includes information about how the Department inspects hospitals and the State's hospital licensure and complaint process. It explains how consumers can file a complaint against a hospital or review an inspection file for further information on an enforcement action. The Department updates the site quarterly with resolved enforcement actions and leaves the information on the website for 15 months.

Information on New Jersey's Website:

Name and address of hospital
Enforcement date
Enforcement action
The issue
General area of Licensing Standards
How the violation was found
Hospital's plan of correction
Hospital's appeal status
Penalty letter sent to the hospital

Source:
<http://www.state.nj.us/health/hcsa/hospfines/hfines.htm>

Making information available to consumers

Over a 6-month period in 1996, the *Asbury Park Press*, a New Jersey newspaper, published a series of articles called "Vital Signs" that examined the quality of hospital care in the State. The series focused, in part, on the lack of information available to consumers on the quality of hospitals. It found that "[hospital] fines are effectively a private matter. Seldom are fines announced or made readily available to the general public, even though such information is a public record. Fines are not printed in any official state publication and no press releases are sent to the media."¹⁸ At the time, a consumer would have to contact the Department and request information about a hospital's violation of licensing standards.

During the publication of "Vital Signs," the newspaper's editorial board met with the Commissioner of the Department to discuss issues raised in the series. The series included recommendations that the Department make information about hospital violations more

available to consumers. In early 1997, the Commissioner's Office began a workgroup to develop a website detailing hospital fines and enforcement actions.

Consideration and concerns about the website's information

When creating the site, the workgroup carefully considered what information to include and how to present it. Because New Jersey keeps information about hospital enforcement actions confidential until the hospital has a chance to respond, the Department makes it clear to the website's readers that the hospital violations listed in the site have been corrected and the hospitals listed are now in compliance. In addition, the website cautions the reader:

Please note that this report offers only a one-time "snap-shot" of hospital performance. To more fully assess the quality of care provided by a hospital, it is important that you review current and past survey reports. You may also wish to discuss hospital services and performance levels with your doctor and with family members or friends who have used the facility.

Given that the information provided is publicly available, the New Jersey Hospital Association does not object to the website. However, it has concerns with how the Department presents the information. It is concerned that visitors to the website will be unable to easily discern the gravity of the deficiencies listed due to the regulatory language used, which may make the complaints seem worse than they actually are. In addition, the Association felt that keeping the information on the website for 15 months was too long, since a hospital would still be listed on it after having rectified the deficiency.

COLORADO: Posting Compliance Summaries on the Internet

On the Colorado Department of Public Health and Environment website, the public can find a compliance history covering the past couple of years for each hospital in the State.¹⁹ The website includes basic information on the hospital, such as its accreditation status, ownership, address, and associated facilities, in addition to summaries of all complaints and serious events, referred to as "occurrences," reported to the State since January 1999.²⁰ The summaries describe the reported incident, what actions the hospital took in response, and the Department's follow-up actions (see the box on the following page for an example). The hospitals are also able to provide responses to the summaries. In the future, the State plans to include a list of deficiencies found during State licensure surveys and Medicare certification surveys in addition to the occurrence and complaint summaries.

Emerging Activity and Refinement

Since 1987, Colorado has mandated that hospitals file occurrence reports with the State. All hospitals, and more recently all licensed health facilities in the State, must submit reports of specific types of incidents within one business day of when the incident took place. Examples of such reportable occurrences include deaths from unexplained causes, missing persons, physical and sexual abuse, and life-threatening reactions to anesthesia or transfusions. In 1995, the Colorado media criticized the confidential nature of these reports. Soon after, the State decided to make summaries of the reports available to the public from their offices in Denver. To make the summaries more widely available to the rest of Colorado, the Department began posting occurrence summaries on the Internet in early 1998 as they were released to the public. More recently, the State has reorganized its database capabilities and its website, and now posts the reports by facility and includes information on complaints.

Occurrence Summary Report

Facility: XYZ

Date of Occurrence: 1/30/99

Report Timely: Yes

Type of Occurrence: Brain Injury

Description of Occurrence: On 01/30/99, a female patient was given 10mgm of morphine for pain intravenously. It was ordered intramuscularly. The patient suffered a respiratory arrest. The patient expired in intensive care on 02/03/99.

Facility Action: The facility was unaware of the medication error at the time of the respiratory arrest. The patient was resuscitated and moved to intensive care. The physician and family were notified. The facility became aware of the medication error about three hours after the medication was given. The physician and family were made aware of the error. The nurse administering the medication was suspended and terminated.

Department Findings: The Department conducted an on-site investigation and a HCFA authorized hospital survey as a result of this occurrence. The facility was cited for deficient practice for not assuring the competency of the nursing staff, for lack of accountability of the governing body and for deficient practice in the quality management functions of the hospital. The Department will conduct ongoing monitoring of facility compliance under the supervision of HCFA. The Department will review all facility occurrences during this monitoring process.

Sent to Facility: 7/27/99

Facility Comment: No facility comment received at this time

Released to Public: 8/6/99

An example of an occurrence summary from the Colorado website.

Recognizing the Sensitivities

With such widely available information, hospitals in Colorado are concerned that what might be an isolated event could be generalized across an entire facility. The media, also, are able to run attention-grabbing stories about incidents from the information made public. In an effort to further educate the public and alleviate any potential concerns from hospitals, the website includes language helping put occurrence reports in context and excludes the names of staff or patients.

CONCLUSION

States rely on both the Health Care Financing Administration (HCFA) and the Joint Commission for the external review of the hospitals operating within their boundaries. They receive funds from HCFA to determine nonaccredited hospitals' compliance with the Medicare conditions of participation and to respond to adverse events and complaints in all Medicare-participating hospitals. Over half the States deem Joint Commission accreditation to meet their State licensure requirements.²¹

State Initiatives as Complements to HCFA and the Joint Commission

The State initiatives presented in this report show that States can draw on their own authorities and resources to add a measure of public protection not provided by either HCFA or the Joint Commission. States have advantages that the other external reviewers would be hardpressed to match. In particular, States are closer to the action in their hospitals than a national reviewer like the Joint Commission could ever be. They are more likely to know the hospitals' histories and the local market and be up-to-date on events such as union disputes and mergers, and trends such as local nursing shortages. As a result, States can act swiftly when needs arise.

These advantages can help States contribute a valuable complement to the existing, national approaches to external review. They can craft oversight initiatives to meet a need unique to their State, like New York did with its surprise surveys that assessed compliance with its residency regulations. Alternatively, they can build on that existing national system of oversight, like Utah, thereby extending that system's value to the State. Or they can develop initiatives that fill in gaps left by the approaches of HCFA or the Joint Commission. Both New York and Pennsylvania did that with their data collection efforts.

State Initiatives as Instructive to HCFA, the Joint Commission, and Other States

States can serve as important catalysts for continued national efforts aimed at improved hospital oversight. In fact, these States' initiatives and others that are underway can be instructive to HCFA and the Joint Commission, as well as to other States.

In our previous series, which examined the roles of HCFA and the Joint Commission, we stressed two themes in our recommendations to HCFA that are reflected in the initiatives highlighted herein: balance and accountability. We called for HCFA to promote balance between approaches to oversight that are collegial (oriented toward education and improvement) and regulatory (oriented toward ensuring minimum protections). This has particular relevance for the use of performance measures, which we called for to be used in ways that not only foster improvements but also in ways that help identify and deal with poor

performers. New York and Pennsylvania's experiences with performance measures demonstrate that such balanced uses are both feasible and constructive.

Our previous series also called for HCFA to better use unannounced hospital surveys as another way to introduce more balance between collegial and regulatory approaches to hospital oversight. New York's recent surprise hospital inspections provide insights into how one State managed to coordinate a State-wide unannounced inspection process.

The other theme from our prior series--increased accountability--is reflected in the States' initiatives as well. New Jersey, Colorado, New York, and Pennsylvania all now have a body of experience with releasing hospital- or physician-specific performance information in various forms. Releasing such information promotes accountability on the part of the hospital as well as the State. Each of these States overcame concerns that have inhibited national efforts at similar disclosures, such as those about risk-adjustment and public misunderstanding the information. Their efforts illustrate the potential of public disclosure as a means to increasing accountability.

Methodology

We identified the initiatives highlighted in this report through a mail survey of State survey and certification agencies, follow-up telephone calls, and a literature review.

As a part of our larger inquiry on the external review of hospital quality, we mailed a pretested survey to the State survey and certification agencies in the 50 States and the District of Columbia in August 1997. The response rate was 100 percent. The State survey addressed four areas of hospital quality oversight: State licensure of hospitals, private accreditation, Medicare certification, and Health Care Financing Administration oversight of State certification agencies. We also interviewed some State officials on the telephone and in person.

We followed up the mail survey with telephone calls in July and August, 1998 to collect more information about hospital licensure and any special initiatives underway in each State. The response rate for this survey was 100 percent.

We identified several State initiatives through the mail and telephone surveys, of which we selected nine for follow-up: Colorado, Massachusetts, New Jersey, New York (two initiatives), Ohio, Pennsylvania, South Carolina, Utah. Our criteria for defining a State initiative in hospital oversight were rather broad: that the initiative be led by the State, that it be implemented as opposed to planned, and that some minimum time with it had elapsed.

With the exception of New York, which we visited on-site, we conducted the follow-up on the initiatives through telephone interviews, reviewing documents, and searching the literature and popular media. Our telephone interviews included not only State officials but also representatives of the State hospital associations for some States. We conducted this follow-up in the fall of 1998 and then updated our information in the summer and fall of 1999. During this time, we eliminated three States from our sample of initiatives: Massachusetts, because its initiative was not led by the State; Ohio, because its experience with its initiative was too limited; and South Carolina, because it abandoned its initiative over the course of our inquiry.

For each of the remaining initiatives, we confirmed the accuracy of our information with officials directly involved in the initiatives.

Endnotes

1. Office of Inspector General, *The External Review of Hospital Quality: A Call for Greater Accountability* (OEI-01-97-00050), *The External Review of Hospital Quality: The Role of Accreditation* (OEI-01-97-00051), *The External Review of Hospital Quality: The Role of Medicare Certification* (OEI-01-97-00052), and *The External Review of Hospital Quality: Holding the Reviewers Accountable* (OEI-01-97-00053), July 1999.
2. New York State Department of Health, *Coronary Artery Bypass Surgery in New York State 1994-1996*. See also Edward L. Hannan et al, "Improving the Outcomes of Coronary Artery Bypass Surgery in New York State" *Journal of the American Medical Association* 271 (March 1994) 10: 761-766.
3. Edward L. Hannan et al, "Investigations of the Relationship between Volume and Mortality for Surgical Procedures Performed in New York State Hospitals," *Journal of the American Medical Association* 262 (28 July 1989) 4: 503-510.
4. Previously, surgeons included in the report had to have performed 200 CABG operations during the 3-year reporting period. (New York State Department of Health, *Coronary Artery Bypass Surgery in New York State 1994-1996*, October 1998, p. 11)
5. Current results are based on data from 1994-1996; the latest mortality rates were released in October 1998.
6. The Department recently reprogrammed its data collection software, enabling hospitals to more readily examine their own data.
7. The DRGs were selected based on their high volume, cost, and wide variation in mortality.
8. "Because of the continuing escalation of costs, an increasingly large number of Pennsylvania citizens have severely limited access to appropriate and timely health care. Increasing costs are also undermining the quality of health care services currently being provided." Health Care Cost Containment Act, P.L. 783, No. 123, Sec. 2 (1992).
9. The Council and the Department did collaborate and combine data for a report on caesarean-section rates.
10. Pennsylvania Health Care Cost Containment Council, *Pennsylvania's Guide to Coronary Artery Bypass Graft Surgery 1994-1995*, May 1998 (98-05/01-07), p.1.

11. Pennsylvania Health Care Cost Containment Council, *Cesarean Section Deliveries in Pennsylvania 1995*, October 1997 (97-10/01-02), p. 1.
12. J.M. Bentley and D.B. Nash, "How Pennsylvania hospitals have responded to publicly released reports on coronary artery bypass graft surgery," *Joint Commission Journal of Quality Improvement* 24 (January 1998)1: 40-49; Ron Winslow, "Making the Grade: Improvements in quality of care suggests hospitals are taking reports cards to heart" *Wall Street Journal*, 19 October 1998, 16.
13. E.C. Schneider and A.M. Epstein "Use of Public Performance Reports: A Survey of Patients Undergoing Cardiac Surgery," *Journal of the American Medical Association* 279 (May 1998) 20: 1638-1642.
14. For the purpose of the inspections, a sample work week for residents was calculated. Bell Regulations limit resident working hours to 80 hours per week, averaged over a 4-week period.
15. It does, however, offer such a website with regard to nursing homes.
16. The website's address is <http://www.state.nj.us/health/hcsa/hospfines/hfines.htm> (accessed September 1999).
17. New Jersey also has websites that have similar information on nursing homes and emergency medical services.
18. Paul D'Ambrosio, "Some Say Low Fines Discourage Hospitals from Following Rules," *Asbury Park Press*, 3 November 1996.
19. The site includes facility profiles for all healthcare facilities in Colorado, including physical therapy clinics, psychiatric hospitals, dialysis facilities, and nursing homes.
20. See <http://www.hfd.cdph.state.co.us/info.asp> (accessed September 1999).
21. Thirty-four of 51 States (including the District of Columbia) deem Joint Commission accreditation to meet their State licensure requirements for hospitals. Of those 34, 5 deem only for the year coinciding with the Joint Commission's on-site survey.